Management Summary

Annual Performance Report

October 1, 2020

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September 30, 2021

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Wakefield, MI 49968
906-229-6100
www.gccmh.org

COMMUNITY MENTAL HEALTH AUTHORITY BOARD

It is the mission of the Community Mental Health Authority (CMHA) Board to enhance the quality of life for our community by offering comprehensive behavioral health services in a trauma-informed culture of care, promoting person-centered planning, integrated healthcare, recovery and community inclusion.

CMH Authority Board: The CMH Authority Board consists of 12 members appointed by the Gogebic County Board of Commissioners pursuant to the Michigan Mental Health Code. Two (2) primary and two (2) secondary consumers were added to the Board per the Mental Health Code changes of 1996.

The Board meets monthly and works with a number of sub-committees that research/study various issues and make recommendations to the full CMHA Board for final action. Sub-committees include: Personnel, Finance, Nominating/By-Laws Review and Steering/Building & Grounds. In addition, there is Board member representation on the agency's Recipient Rights Advisory Committee, the agency's Consumer Advisory Council, the agency's Anti-Stigma Committee, the NorthCare Network Governing Board and the NorthCare Network Customer Services Committee. Board members also are members of the Great Lakes Rural Mental Health Association and the Community Mental Health Association of Michigan.

FY 21 Board members included: Steve Thomas, (Chairperson), George Beninghaus, (Vice Chairperson), Bob Lynn, (Secretary/Treasurer), Patricia Crabtree, Valerie Swanberg, Dan Siirila, Ken Wegmeyer, Colleen Kichak, Carrie Braspenick, Joe Bonovetz, Bill Malloy and Scott Erickson.

Chief Executive Officer: The CEO is responsible for the overall day-to-day operation of CMHA Board-operated services including: all personnel, contracted services, planning, policy development, risk management, training, quality assurance, capital outlay and physical plant improvements.

The CEO is hired and employed by the CMHA Board. The CEO has direct supervision over three department directors: Clinical Services, Finance (Board Administration) and Community Services. The CEO also has direct supervision over the positions of CMHA Board's Secretary/ Administrative Assistant, Quality Improvement Coordinator/Corporate Compliance Liaison, Recipient Rights Officer/Contract Manager, Network Support Analyst, Information Systems Analyst, Human Resources Coordinator and Maintenance Coordinator.

Under the direction of the CMHA Board of Directors, the CEO is responsible for the overall administrative operations of the County-wide comprehensive community mental health system. The CEO executes and administers CMHA programs in accordance with all applicable procedures, regulations and provisions outlined by the Michigan Mental Health Code as it exists or amended. The CEO is responsible for planning, budgeting and general policy guidelines established by the Board as well as administration of the full master contract with the Michigan Department of Health and Human Services, NorthCare Network PIHP-CMHSP Contract and other contracts and conditions as appropriate. The CEO supervises, coordinates and directs work of the Program Directors as needed. The CEO oversees agency-wide strategic planning,

program development and Board Committee work as assigned. The CEO ensures compliance with all clinical and administrative policies, directives and procedures of CMHA.

Finance Director: The Finance Director is responsible for all financial reporting and preparing the agency budget in coordination with the CEO and the management team. The Finance Director is responsible for the Board Administration and Finance Departments and its personnel; this includes Medical Records, Accounts Payable, Payroll, Accounts Receivable, Purchasing, Data Coordinator and Administrative Service Professionals.

Clinical Services Director: The Clinical Services Director is responsible for overseeing services for adults with a serious mental illness (SMI), children with a serious emotional disturbance (SED) and/or SMI adults or SED children with co-occurring disorders. The Clinical Services Director oversees all programs within the outpatient/clinical services department and ensures that services provided meet contractual requirements. The Clinical Services Director directly supervises the Mental Health Access/Juvenile Justice Diversion Project, the SED Child and Family Services Supervisor, the Crisis Intervention/Emergency Services Supervisor, Initial Access/Intakes/OP Therapy Services & Utilization Management, Psychiatry & Nursing Services, the Assertive Community Treatment Supervisor/Team Leader, the SMI Adult Supports Supervisor and the SMI Adult Drop-In Center Program Manager.

Community Services Director: The Community Services Director is responsible for services for individuals with intellectual/developmental disabilities. This position supervises the Community Services, Applied Behavior Analysis, Rehabilitation and Residential Services programs and staff working within those programs. They also oversee the specialty contracts for Physical Therapy services, Occupational Therapy services and Board-Certified Behavior Analyst services and the Behavior Psychologist. The Community Services Director is responsible for overseeing services to all individuals with intellectual/ developmental disabilities who reside out of county; as well as, the agency's Habilitative Supports Waiver Coordinator.

Recipient Rights: The Recipient Rights Officer (RRO) is responsible to assure that agency policy and practices are in compliance with State Office of Recipient Rights Guidelines. The RRO is charged with protecting the rights of recipients by providing rights training, investigating reported rights violations and reviewing all incident reports. The RRO shall initiate investigation of apparent or suspected rights violations in a timely and efficient manner. The determination of whether an investigation was initiated immediately when there is an allegation of abuse, neglect, serious injury, or death of a recipient which involves an apparent or suspected rights violation, shall be based on the action by the rights office on receipt of the complaint. Steps to initiate an investigation shall be taken within 24 hours of the receipt of the complaint and shall be comprised of proactive rights activities. The RRO shall complete the investigation no later than 90 days after it receives the rights complaint and shall determine whether a right was violated by using the preponderance of the evidence as standard of proof. The RRO shall issue a written status report every 30 calendar days during the course of the investigation, submitted to the complainant, the respondent and the responsible mental health agency. Upon completion of the investigation, the RRO shall submit a written investigative report to the respondent and the responsible mental health agency. Within 10 business days of the investigative report, a summary report will be prepared and sent to the complainant and recipient and guardian (if

recipient has a guardian). The RRO conducts the quarterly Recipient Rights Advisory Committee meetings. The rights office is responsible for assuring rights protection is provided to all recipients of services in ALL service settings (CMHA run and contracted services).

The RRO also serves as the Contract Manager (CM) who is responsible for the management of Gogebic CMHA's contracts and the contracting process and is the liaison between Gogebic CMHA and contractors/vendors. The CM leads contract procurement through the competitive bid process and prepares contracts according to policies and procedures. The CM participates in CMHA and contracted site reviews to assure compliance with licensing, rights, etc. The CM sits on the regional Contract Management Committee and the Statewide Contract Managers Networking Committee.

The RRO also serves as the Training Coordinator, scheduling and coordinating New Employee Orientation, assigning required trainings to staff and entering completed trainings into the My Learning Pointe system.

The RRO also serves as the Customer Services Coordinator. The CSC files non-Rights related grievances into the ELMER system and fields Customer Services inquiries.

Human Resources (HR) Coordinator: The HR Coordinator assists the CEO in coordinating all areas of agency HR functions such as recruitment, retention, employment, placement, wage and salary administration, discipline, union negotiations and training concurrent with agency policies. The HR Coordinator is responsible for agency personnel matters including files, laws, policy/procedures, compensation/fringe benefit plans and the like, as well as coordinating agency efforts toward EEOC, FMLA, ADA, FLSA, OSHA, COBRA and HIPAA compliance. The HR Coordinator also monitors and facilitates the agency's health insurance, worker's compensation program, unemployment claims, other benefits administration and maintains, develops and implements all employee records and information, as well as, compiles, enters and retrieves personnel data. In addition, the HR Coordinator co-manages the agency's training program and organizes/ conducts new employee orientation and serves as an active participant on the Credentialing & Privileging Committees.

Quality Improvement (QI) Coordinator / Corporate Compliance Liaison: Duties of the QI Coordinator / Corporate Compliance Liaison include: coordinate the Quality Assessment and Performance Improvement Program (QAPIP), be an Ad Hoc member of all QI work groups, assist with the development, implementation and maintenance of agency policies and forms, assist with the agency strategic planning and management reporting, maintenance of CARF Accreditation, liaison for external site reviews and chairs the agency's Consumer Advisory Council, Quality Improvement/Utilization Management (QI/UM) Committee and Anti-Stigma Committee.

The Board's QAPIP has developed an organizational structure for evaluation, goal attainment and continuous quality improvement. This structure is parented by the Steering Committee. The Committee has the responsibility to maintain a corporate culture based on continuing QI philosophies and to oversee its progress and for the design and operation of the structure and systems to support QI. The Steering Committee is comprised of the CEO, Program Directors and the QI Coordinator. To assist the Steering Committee in carrying out the Board's mission, a QI/UM Committee is maintained for the purpose of reviewing QAPIP activities, reviewing and

analyzing data and recommending changes for service improvement on an on-going basis, and will serve as a medium for communication and integration across all areas of quality improvement throughout the agency. Standing members of the QI/UM Committee shall be the QI Coordinator, Clinical Services Director, UM Coordinator, the Recipient Rights Officer/Contract Manager/Safety Committee Rep, the Medical Records Coordinator and representatives from the I/DD/MI Children Adult populations. The Medical Director/designee participates in the meetings as needed. The QI/UM Committee meets as needed, but not less than quarterly.

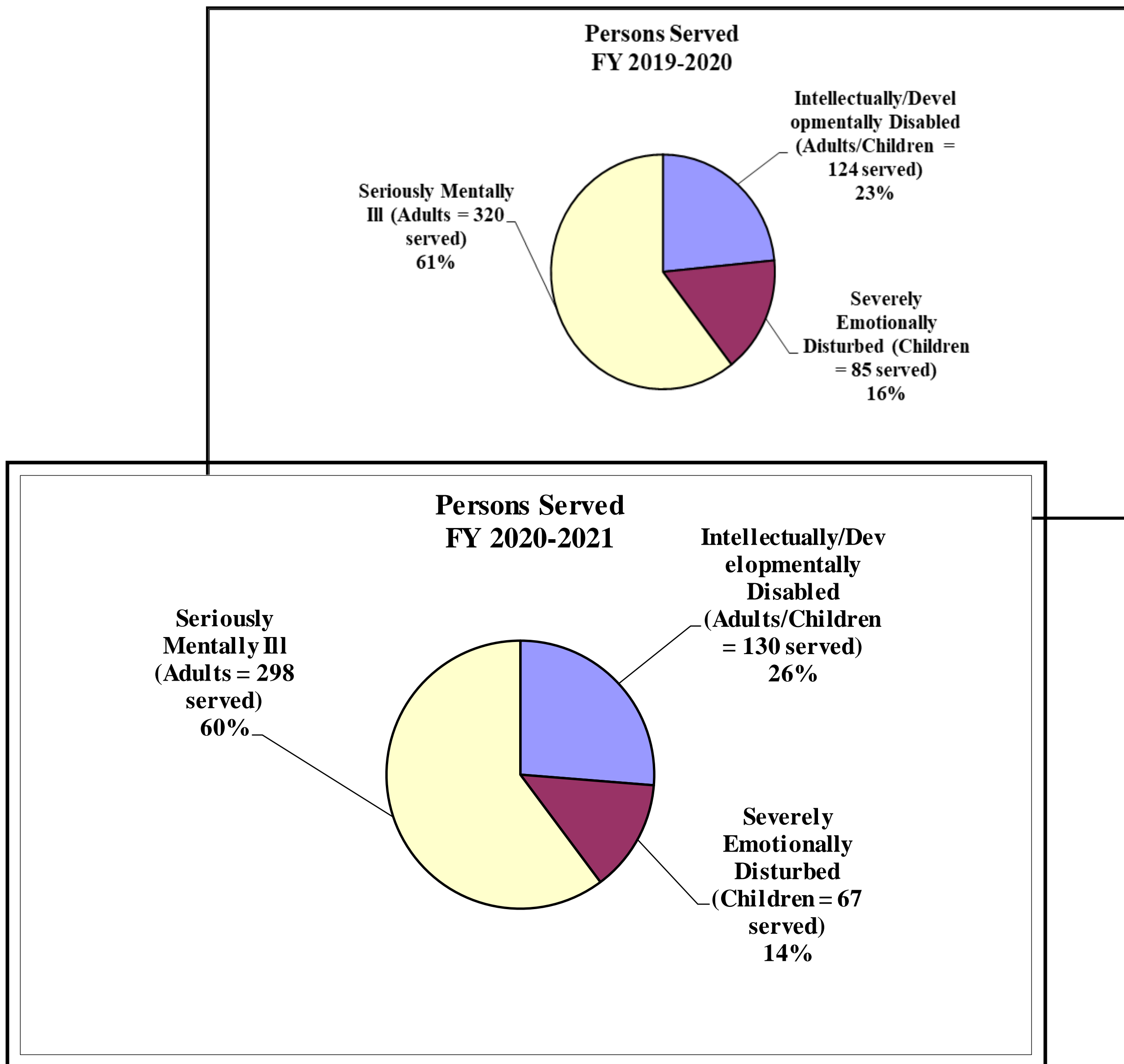
Maintenance Coordinator: The Maintenance Coordinator is responsible to perform repairs, snow shoveling/blowing/plowing, mowing grass, maintaining buildings and grounds, coordinating agency vehicle maintenance, assisting with building security and safety and coordinating maintenance/repairs with the lessee when a leased building is involved. The Maintenance Coordinator is responsible for the direct supervision of the Custodian/Maintenance Assistant.

Available Services

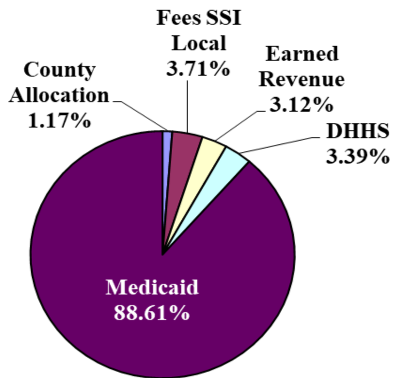
CMHA provides a variety of services for individuals with serious mental illness, serious emotional disturbance, and/or co-occurring disorder, and/or intellectual/developmental disabilities. Some of the services include Community Inpatient, Case Management/Supports Coordination, Therapy, Jail Diversion, Medication Administration and Home Based; a complete listing of services provided is available by contacting CMHA. The programs specifically accredited by *CARF International - Commission on Accreditation of Rehabilitation Facilities*, include Case Management / Services Coordination (Adults, Children & Adolescents), Community Housing (Adult Residential), Employment Services (Supported Employment & Job Development) and Assertive Community Treatment (Adults).

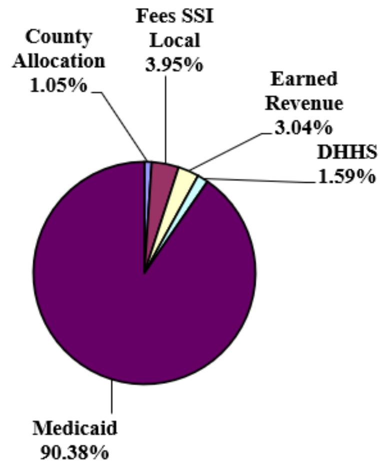
Persons Served

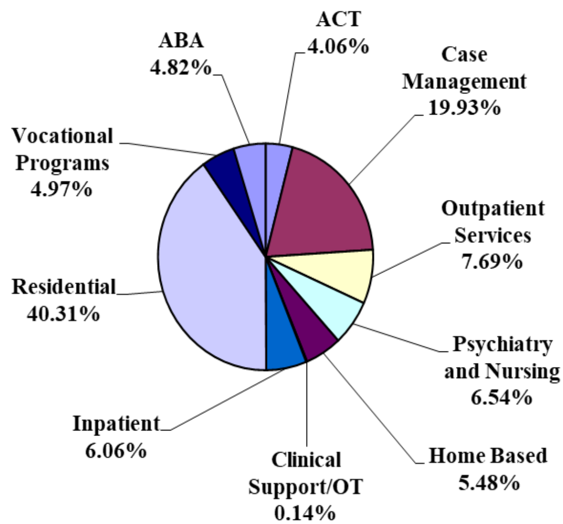
495 individuals received reportable services during FY 2021; this is a decrease of 34 individuals served from last fiscal year. A break down per population is shown in the graph below, with a comparison to last fiscal year.

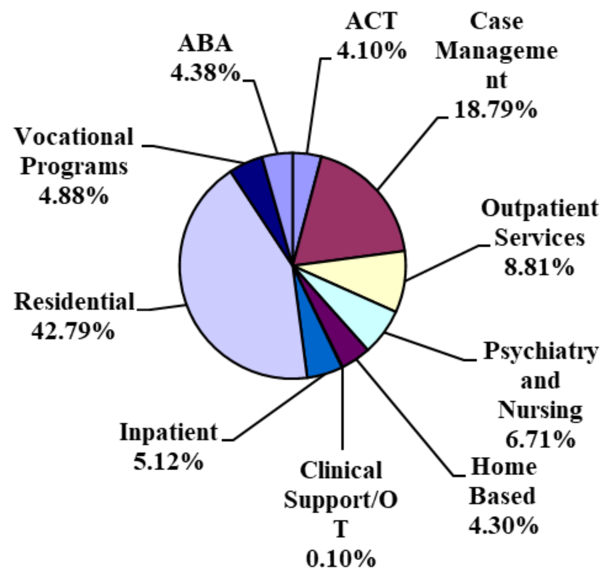


Financial Profile FY 2021
(with comparison to FY 2020)









Quality Assessment and Performance Improvement Program (QAPIP)

Outcomes Summary for FY 2021

(with Quality Improvement Plans for FY 2022)

Quality Improvement/Utilization Management (QI/UM) Committee

- The Committee continued to meet quarterly to review various QI and UM data (i.e., satisfaction, performance indicators, program outcomes, record review, incidents, etc.), to receive QI sub-committee updates and to review regional data.

➢ *QI Plan FY22*

  - Continue to meet not less than quarterly to develop, implement and monitor all aspects of the QI program.

Utilization Management (UM)

- The number of individuals participating in various Evidence Based Practices programs (i.e., Assertive Community Treatment, Infant Mental Health, etc.), approved/denied assessments, inpatient pre-admission screenings and diversion data continued to be monitored and discussed during quarterly QI/UM Committee meetings.

➢ *QI Plan FY22*

  - Continue to develop, implement and monitor all aspects of the UM system.

Safety and Risk Management Committee

- The Committee conducted numerous disaster drills in the CMHA main building throughout the fiscal year. There were no disaster drills conducted at the Serenity Center due to staffing issues and the Center being closed due to the COVID pandemic. There were a variety of drills and inspections conducted at the three CMHA-operated residential homes. Routine vehicle inspections were conducted throughout the fiscal year on agency fleet vehicles utilized at the CMHA main building and at the residential homes. The Maintenance Coordinator conducted internal building inspections at the CMHA main building.

- A Michigan Certified Building Inspector conducted the Annual Safety Inspection on October 21, 2020 with no items of concern noted. The sprinkler system was inspected and certified on April 27, 2021.

- The annual inspection of the First Aid bags located in agency vehicles and in the CMHA main building continue to be conducted, with restocking of the supplies, as needed. The First Aid bags located in the residential homes and at the Serenity Center were also inspected by other CMHA staff and restocked with required supplies, as needed.

- There were 12 staff injuries (17 less than FY 20) resulting in 1 with lost time or need for accommodation (compared to 6 lost time or need for accommodation in FY 20). The Safety Committee reviewed all injuries and provided follow-up analysis and recommendations to minimize future injuries, as well as noting any trends/patterns in injury.

- There were 354 recipient incidents (duplicated count) for FY 21; this is a significant decrease from 500 incidents in FY 20. Incidents can be coded for multiple categories; hence, some incidents are counted more than once (duplicated count); for example: a recipient experienced an (1) *accidental serious injury from fall*, which resulted in (2) *emergency medical treatment due to injury*, then it resulted in the recipient being (3) *hospitalized due to*

injury (three different categories). The highest number of incidents is 67 for the category of "refused medication"; the next highest is 57 for the category of "non-serious physical aggression". Medication incidents increased from last fiscal year, from 63 (FY 20) to 77 (FY 21). The QI/UM, Safety, and Pharmacy & Therapeutics/Medical Services Committees continue to monitor the various incidents for patterns and/or trends. Training for staff and proactive strategies are implemented, as needed, to assist in decreasing incidents. Applicable staff continued to address individual consumer risk for injuries with follow-up intervention as directed and recommended, including behavior treatment plans, psychiatric medication monitoring, fall-prevention guidelines and assessment for and utilization of adaptive equipment, assistive devices, durable medical equipment and anatomical supports.

- As a commitment to promoting accessibility, representatives from the Safety Committee provided safety-related quarterly progress reports for the Accessibility Plan, to include identifying and eliminating barriers, with reasonable accommodation, when identified.

- The Safety Committee reviewed agency policies and procedures relating to health, safety and transportation to assure on-going compliance with indicators and standards established by CARF and other regulatory agencies.

➢ QI Plan FY22
  - Continue quarterly Safety & Risk Management Committee meetings.
  - Continue to monitor the Strategic Plan's health and safety goals and objectives.
  - Continue to monitor medication, health and safety incidents and implement prevention and pro-active plans, as needed.
  - Continue quarterly reviews of the Accessibility Plan and update, as needed.
  - Review agency policies and procedures and assure continued compliance with applicable CARF standards and other regulatory agencies relating to accessibility, health, safety and transportation.

Pharmacy & Therapeutics/Medical Services Committee

- The Committee met quarterly and consisted of agency RNs, Clinical Services Director, Psychiatrist/Medical Director and Physician. The Committee reviews and monitors all pharmacy and therapeutic related data (i.e., medication incidents), applicable policies and procedures, conducts Peer Reviews and discusses any infection control issues, as well as the Infection Control Committee, that also meets quarterly.

➢ QI Plan
  - Continue to monitor medical and medication incidents and implement prevention and pro-active plans, as needed.
  - Continue to conduct annual Peer Reviews.
  - Continue Pharmacy & Therapeutics/Medical Services Committee and Infection Control Committee meetings and responsibilities.
  - Review agency policies/procedures relating to medical/medication services to assure continued compliance with applicable CARF standards and other regulatory agencies.

Strategic Plan

- Strategic Plan goals and objectives were reviewed and updated quarterly.

- ➢ *QI Plan FY22*
  - Maintain quarterly monitoring of the Strategic Plan goals and objectives, encouraging input from CMHA Board and staff.

Outcomes Management System (OMS)

- The OMS is a systematic procedure for determining the effectiveness and efficiency of results achieved by the persons served during service delivery or following service completion and of individual satisfaction with those results. The function of the OMS is to collect and monitor outcome goals and objectives developed by QI work groups for the agency's CARF accredited programs. Although not CARF accredited, goals and objectives for Customer Services continued to be monitored, as well. OMS data for the fiscal year shows 67% overall compliance, an increase from 65% last fiscal year (includes access goals but does not include satisfaction or Customer Services data – see *Satisfaction Surveys* section of this report). Areas of non-compliance were continually monitored by the QI/UM Committee.

- *Michigan Mission-Based Performance Indicators (CMHSP)* ~ Four of the five indicators monitored have an established compliance threshold of 95%. Indicators #1 & 3 were compliant for the entire fiscal year, scoring 95% or above for all quarters. Indicator #2 was compliant for only one quarter of the fiscal year (the non-compliant scores were 90.32%, 86.96% and 82.29%), and Indicator 4A was compliant three of the four quarters (one was 50%). The fifth indicator (#10) monitored has a '15% or less' compliance threshold and monitors children and adults who are readmitted to an inpatient psychiatric unit within 30 days of discharge. CMHA was compliant with this indicator for three of the four quarters in the fiscal year; the one quarter not compliant scored 20% (1 of 5 individuals was readmitted to a psychiatric unit within 30 days of their discharge).

- *Pre-paid Inpatient Health Plan (PIHP) Performance Indicators* ~ The indicators monitored mirror those for the *Michigan Mission-Based Performance Indicators*; however, they focus solely on *Medicaid* beneficiaries served. Indicator #1 was compliant three of the four quarters (non-compliant score was 94.12%). Indicator #2 was compliant for only one quarter (non-compliant scores were 90%, 85.71% and 89.29%). Indicator #3 was compliant three of the four quarters (non-compliant score was 94.74%). Indicator #4A was compliant three of the four quarters (non-compliant score was 50%). The fifth indicator (#10) has the '15% or less' threshold was compliant three of the four quarters; non-compliant score was 20% (1 of 5 individuals was readmitted to a psychiatric unit within 30 days of their discharge).

- ➢ *QI Plan FY22*
  - Continue to monitor and maintain the OMS, making modifications to increase compliance, as needed.
  - OMS work groups to review and modify the goals and objectives and the Program Descriptions and Plans, as needed for FY 22.
  - Continue to monitor all performance indicators.

Performance Improvement Projects (PIP)

Standards published by the Centers for Medicare and Medicaid Services (CMS) require that the PIHP "conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and consumer satisfaction." Two PIPs are required by MDHHS (Michigan Department of Health

and Human Services), one project topic may be mandated by the State. In addition, NorthCare is an accredited Health Plan through the Utilization Review Accreditation Commission (URAC), which requires *three* PIP's. All three PIP's must focus on clinical quality and at least one of the three must address recipient safety for the population served.

- PIP #1 ~ *Documentation/Supported Employment/Skill Building*: This project continued from FY 19. In FY20, CMHA staff provided ELMER training to Highline staff, and in FY21 Highline transitioned from paper vocational Progress Notes to (electronic) ELMER Progress Notes.

- PIP #2 ~ *Engagement in Service*: This clinical project focuses on increasing the number of persons who receive services for at least 90 days after initial assessment indicates eligibility for mental health services. This project is monitored by the regional UM Committee and they continue to discuss and implement strategies to keep individuals involved/increase engagement in services across the region. FY 21 data was not received from NorthCare regarding this project.

- PIP #3 ~ *Follow-Up After Inpatient Psychiatric Hospitalization Discharge - 7 Days (the percentage of discharged enrollees age six (6) and older who were hospitalized for treatment of selected mental illness diagnoses, and who had a follow-up visit with a mental health practitioner within seven (7) days of discharge)*: This PIP is on-going from prior years. NorthCare's plan is to continue to revise and monitor this PIP to ensure members receive a service within 7 days of discharge. This project will be adjusted to account for additional face-to-face services that are outside the HEDIS code sets. HEDIS does not include the T1016/T1017 as they are not required to be provided face-to-face on a national level; however, in Michigan in order to report or pay for these services they must be provided face-to-face. In addition, the T1016/T1017 services are typically provided by the primary case holder so it makes sense that these services be counted for in this measure. FY21 will establish a new baseline with the goal being to achieve a statistically significant improvement over the new baseline.

➢ *QI Plan FY22*
  - Continue to participate in the regional PIPs as required.

Record Review and Service Verification

- For FY 21, there were 40 records reviewed with 56 indicators monitored the first two quarters, and one indicator added starting in quarter three. Data analysis reports were developed from the quarterly record reviews that were conducted. Of the 57 indicators, 5 indicators were not applicable for the entire fiscal year. Of the 52 applicable indicators, 40 scored as "met" (95% or higher) for an overall compliance score of 77%; of the 40 compliant indicators, 34 scored a perfect 100%. In comparison, FY 20 had 5 of the 56 indicators not applicable for the entire fiscal year. Of the 51 applicable indicators, 41 scored as "met" (95% or higher) for an overall compliance score of 80%; of the 41 compliant indicators, 30 scored a perfect 100%. A trend continued with one indicator being non-compliant for all but one quarter in the past four fiscal years; observations were provided to the (service) Program Directors, along with any trends regarding individual provider non-compliance.

- CMH's Service Verification process, which mirrors NorthCare's process, shows in FY 21 that all four quarters scoring 100% compliance for the 10 Service Activity Logs (SALs) and the 10 Claims selected for review each quarter. CMH's Service Verification, however,

includes *all* services where NorthCare's service verification process is specific to *Medicaid* only.

- NorthCare's Service Verification audits focus only on *Medicaid* services. FY21 data shows of the 41 claims reviewed, 40 were found to be valid. The 1 claim invalid has since been corrected. All 40 SALs reviewed were found to be valid.

- Highline Service Verification was only done in Q1; 3 charts were reviewed with 108 scoring sections/indicators reviewed with 100% compliance. Starting with Q3, Highline Service Verification was incorporated into CMH's record review process.

➢ *QI Plan FY22*
  - Continue CMH quarterly record reviews and data analysis reports with recommendations to increase compliance, as applicable.
  - Continue to calculate individual provider record review and indicator compliance on a quarterly basis and provide results to the (service) Program Directors for the purpose of including "*Findings of Documentation Review*" on individual performance evaluations, as required by NorthCare.
  - Continue to provide record review data to the CEO, (service) Program Directors and to providers to review and discuss ways to assure compliance.
  - Continue quarterly Service Verification reviews.
  - Continue record review education and training for staff.

Input from the Persons Served and the Community

- Input, suggestions and recommendations received from the persons served, their families, guardians and the community is valued, is a vital part of service improvement and is one of the best ways to assist the agency in improving the services that are provided. Input is received through various ways, such as the suggestion box, satisfaction surveys, grievances via Customer Services and representation on the CMHA Board and various committees. There was only one suggestion received from a consumer (suggestion and response was posted throughout CMH building and provided to residential homes). There was one concern received via the suggestion box which pertained to agency COVID procedures (response was emailed to all staff). There was one grievance received via Customer Services (three less than FY 20) and it was resolved within the required 90-day time frame. All information was reviewed by the QI/UM Committee, with no trends or patterns noted.

➢ *QI Plan FY22*
  - Continue to receive, review and respond to input as appropriate.

Education

- Required training for staff continued to be assigned, provided and monitored. Staff also participated in various competency-based trainings relating to their specific job responsibilities.

- For Calendar Year 2021, CMHA staff provided and/or sponsored three trainings in/for the community, various topics included: Crisis Prevention Intervention (2x) and Mental Health First Aid. Other training opportunities were limited due to the COVID-19 pandemic.

- *QI Plan FY22*
  - Continue to implement NorthCare's '*Member CMHSP Trainings*' and assure required training is assigned. Assign additional trainings as needed and/or requested.
  - Continue to monitor training via myLearningPointe and enter 'other/external' trainings that staff participate in.
  - Schedule/participate in/provide/sponsor community education trainings as needed and/or requested and track such trainings, as allowable due to COVID.

Site Surveys

- **CARF**: The CARF resurvey was conducted in May 2019 which resulted in another 3-year Accreditation Award. The Year-3 Quality Improvement Plan (QIP) was submitted to and accepted by CARF in May 2021.

- **NorthCare**: The NorthCare annual site review was conducted remotely, in the Fall of 2021 and the overall score was 98.8%. Although there were two indicators scored as "partially met" and one indicator scored as "not met", the compliance score is considered 'full compliance'. A Plan of Correction (POC) is due to NorthCare in Jan 2022. FY 21's score is a slight decrease from FY 20's score of 99.1%.

- *QI Plan FY22*
  - Assure on-going compliance with applicable CARF standards. Apply and prepare for the CARF Accreditation Survey that will be conducted in the summer of 2022.
  - Submit the NorthCare POC by due date of January 28, 2022. Assure on-going compliance with applicable NorthCare protocols. Prepare for FY 22 site review.

Other Surveys

- Throughout the fiscal year, CMHA's three residential group homes experienced various safety reviews (fire safety inspection by the State Fire Marshall/Department of Licensing and Regulatory Affairs, annual fire extinguisher inspection/service [J.F. Ahern], smoke alarms/sprinkler systems).

- The Department of Licensing and Regulatory Affairs conducted a licensing inspection at the Ayer group home with no concerns or issues identified, and the Adult Foster Care license was renewed for another two years at that home (the other two homes had been inspected in FY2020).

- All three homes experienced a NorthCare Desk Audit and MDHHS Desk Audit with excellent scores.

- CMHA staff conducted annual site reviews (virtually, due to COVID) at CMHA's residential homes and at Highline Corporation; all four sites received an overall compliance score of 100%.

- *QI Plan FY22*
  - Assure on-going compliance with applicable standards and indicators specific to the licensed residential group homes.
  - Assure annual site reviews are conducted at the CMHA-owned residential group homes and at Highline Corporation.

Consumer Satisfaction Surveys

- Satisfaction surveys were distributed monthly to various recipients. Data is reviewed by the CMHA Board, the QI/UM Committee, the Consumer Advisory Council and staff.

- The FY 2021 satisfaction results for each CARF accredited program (Case Management, Assertive Community Treatment [ACT], Employment Services [Supported Employment], Community Housing [Residential] and Crisis Intervention [Emergency Services]), along with satisfaction results for programs not CARF accredited (Outpatient, Home Based, Peer Supports, Applied Behavior Analysis and Serenity Center) are noted below:

  - Case Management = 94.1% (established goal is 95%) [CARF-accredited program]
  - ACT = 100% (established goal is 95%) [CARF-accredited program]
  - Residential = 100% (established goal is 95%) [CARF-accredited program]
  - Supported Employment = 100% (established goal is 95%) [CARF-accredited program]
  - Home-Based = 100%
  - Outpatient = 100%
  - Serenity Center = NA/no surveys were mailed as the center was closed most of the year due to COVID-19
  - Peer Supports = 100%
  - ABA = 100%

  Overall satisfaction rate for FY2021 = 96.2% (established goal is 95%; does not include Emergency Services). Overall return rate = 16.5% (61 surveys returned out of 369 distributed; does not include Emergency Services).

  Crisis Intervention [Emergency Services] satisfaction result is noted below:

  - Crisis Intervention [Emergency Services] = 100% (established goal is 80%) [CARF-accredited program]. Overall return rate = 7.87% (10 surveys returned out of 127 distributed) NOTE: This data is calculated on a quarterly basis, the other programs above are calculated bi-annually.

➢ *QI Plan FY22*

  - Continue to assess satisfaction with CMHA services and programs.

Consumer Comments on Satisfaction Surveys

❖ We love ABA!! Chloe feels very comfortable with Becky, Chiara, Miranda. They have been so helpful.

❖ CMH should build a low income apartment building with key cards to open to doors like the one in Detroit, MI. It's called Mack-Ashland Apartments.

❖ I feel that I am completing more tasks on my own.

❖ Was told by case manager if I thought of moving while reporting symptoms then Joe made me come in and said he would have said the same. Poor management of prescriptions. They don't help much and are paid to. Also, GCMH tried to skip my appointment after complaint and meeting with Joe. Also, he would not help in any way to help get meds after emailing which I have a copy. People who work in these settings should in my opinion have a clergy man mentality and oath of do not harm!

❖ Wendy and Laurie CLS worker are both very nice to work with. They always help if I have questions and with any advice.

❖ Excellent staff and resources available to me. I am facing an uphill battle with my knees, back, causing depressive symptoms. My therapist and staff are quite helpful. Still I feel overwhelmed at times and unable to lose the weight I need to in order to have surgery.

- ❖ Good Job
- ❖ Doing good
- ❖ We have been extremely satisfied with the referrals Leah has provided with us. Dr. Burrows has updated (consumer's) prescriptions which in turn, have lifted her spirits and enables her to participate more fully in life and activities at Keenagers. Dr. Burrows "zooms" with us every three months to review medications.
- ❖ My case manager Laurie is very good. She truly goes above and beyond. My life has seriously improved. I'm very thankful. My case manager Laurie is really helping me.
- ❖ Everyone is nice there.
- ❖ I'm just worried about my future, that's all.
- ❖ Really love Dr. Burrows, Karin Andrus, Stephanie, and Amanda at the front desk, Lew RN.
- ❖ I hope that it is true that I truly do not need psychiatrist care. I was told I no longer needed to see a psychiatrist.
- ❖ I am sorry this is late. We've had ongoing issues, including a death in the family.
- ❖ We are very happy with the services (consumer) receives. During COVID he has really missed the social aspect of being at Highline and will be happy to get back to his "friends" there and routine. Nicole does an excellent job working with him.
- ❖ Karl is very nice and helpful and I consider him a friend but I have a hard time hearing him when he speaks. He is too quiet. I have to continually ask him to please speak up. My hearing is fine as I can hear fine. It's very frustrating as you can imagine. Again, I really like Karl and we get along fine. We have similar interests. I will say too that I really miss Joe. I know many feel the same way. He retired early at only 62, how odd.
- ❖ I brought my 12 year old child in who wanted to commit suicide and we met with various people but nothing was done to help. The psychiatrist wouldn't even see them because they had trouble sleeping and wanted the primary doctor to put them on sleeping pills before seen. Would not recommend to anyone.
- ❖ Thank you all.

Supported Employment Review

- Supported Employment (SE) Reviews were utilized as part of the agency's Outcomes Management System Data Collection. A sampling of SE Program and Employee Reviews were distributed quarterly to contract sites and community placements.

- All surveys returned (7 of 12) by employers indicated 100% satisfaction with SE services they received. Satisfaction with the individual's job performance at their place of work was 100%.

Comments on Supported Employment Reviews

- ❖ "Name" is a pleasure to have here. She really has opened up to the other girls. She's not afraid to jump in and dust and vacuum when there's no laundry.
- ❖ I don't have any suggestions to improve your program. We are happy with "Name's:" work and have seen a lot of personal development in her over the time she has worked for us.
- ❖ Any problems I have SE Tech takes care of it right away. "Name" is ok – everything is good.

*Note: The SE Department considered all recommendations from employers and addressed them as needed.

PLEASE NOTE:

This Management Summary includes just that ~ <u>summary</u> information. For more detailed reports regarding satisfaction, safety, record review, recipient rights, etc., please request through the Quality Improvement Office.